Appendix 6

Sample Compound Drug Claim Form

Form 98–1142 (8/98)
Authorized under HFS 106.03 (1), Wis. Admin. Code

Return to:

EDS
6406 Bridge Road
Madison, WI 53784–0002

I.M. Provider
1 West Williams
Anytown, WI 55555

12345678

Wisconsin Medicaid

COMPOUND DRUG CLAIM FORM

RECIPIENT INFORMATION

1234567890	Recipient	Ima	2	08/28/72

CLAIM INFORMATION

AB1111111	01/01/01	01/01/01	00 00	14	210
1234567	00		12		

COMPOUND INGREDIENTS

1.	00469	0469 61	100	$X.XX	13.			$
2.	03976	9042 10	10	$X.XX	14.			$
3.	00469	8600 60	50	$X.XX	15.			$
4.	00469	1187 25	30	$X.XX	16.			$
5.	00517	7210 25	10	$X.XX	17.			$
6.	00186	1199 35	10	$X.XX	18.			$
7.				$	19.			$
8.				$	20.			$
9.				$	21.			$
10.				$	22.			$
11.				$	23.			$
12.				$	24.			$

I certify the services and items for which reimbursement is claimed on this claim form were provided to the above named recipient pursuant to the prescription of a licensed physician, podiatrist, or dentist. Charges on this claim form do not exceed my (our) usual and customary charge for the same services or items when provided to persons not entitled to receive benefits under Wisconsin Medicaid.
I understand that any payment made in satisfaction of this claim will be derived from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be subject to prosecution under applicable federal or state law.

PHARMACIST' SOR
DISPENSING PHYSICIAN' S
SIGNATURE I.M. Provider DATE 01/01/01

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PLACE OF SERVICE (POS)	DESCRIPTION
00	PHARMACY
01	HOME (IV–IM SERVICES ONLY)
07	SKILLED CARE FACILITY
08	SUB-ACUTE CARE FACILITY
10	OUTPATIENT (DOCTOR' S

21. TOTAL CHARGES $XX.XX
22. O.C. AMOUNT
23. PATIENT PAID
24. NET BILLED $XX.XX

Appendix